CENTRAL OHIO EYE PHYSICIANS AND SURGEONS

262 NEIL AVENUE, SUITE 420; COLUMBUS OH 43215 * TEL: 614-224-4297 * 1-800-537-2000 * FAX: 614-224-5668

PATIENT NAME	MARITAL STATUS S M W D
DATE OF BIRTH AGE SEX	SOCIAL SECURITY #
ADDRESS	HOME PHONE
	WORK PHONE
CITY STATE ZIP CODE	CELL PHONE
EMPLOYER	OCCUPATION

NAME OF SPOUSE OR PARENT (IF PATIENT IS A CHILD)

NAME OF FRIEND/RELATIVE FOR EMERGENCY CONTACT PHONE #

PLEASE DESCRIBE TYPE OF EYE PROBLEM YOU ARE HAVING

NAME/ADDRESS OF REFERRING DOCTOR

NAME/ADDRESS/PHONE # OF FAMILY DOCTOR

NAME/ADDRESS/PHONE # OF PREFERRED PHARMACY

DO YOU WEAR GLASSES? YES NO	DO YOU WEAR CONTACT LENSES: YES NO

LIST ANY EYE INJURIES OR SURGERIES (INCLUDING LASIK OR OTHER REFRACTIVE EYE SURGERY)

HAS ANYONE IN YOUR FAMILY HAD THE FOLLOWING CONDITIONS: YES NO

( ) CATARACT ( ) GLAUCOMA ( ) MACULAR DEGENERATION ( ) CROSSED EYES

DID YOU GET THE PNEUMONIA VACCINE? **YES NO**	DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS: YES NO	
DID YOU GET THE FLU SHOT? **YES NO**	**( ) HIGH BLOOD PRESSURE** **LAST READING**	( ) DIABETES LAST A1C
DO YOU SMOKE? YES NO HOW MUCH?	( ) HEART PROBLEMS	
DO YOU DRINK ALCOHOL: YES NO HOW MUCH?	( ) BREATHING PROBLEMS	
	( ) HIV ( ) AIDS	
RECENT SURGERIES (PAST YEAR): YES NO	**ANY OTHER DISEASES:**	

ARE YOU TAKING ANY MEDICATIONS: YES NO IF YES, PLEASE LIST NAMES AND DOSAGE (OR PROVIDE A LIST)

ALLERGY TO MEDICATION: YES NO IF YES, PLEASE LIST (OR PROVIDE A LIST)

REFRACTIONS (A TEST USED TO EVALUATE AND OBTAIN YOUR BEST VISION) ARE USUALLY NOT COVERED BY MOST INSURANCE COMPANIES. THE PATIENT OUT-OF-POCKET RESPONSIBILITY FOR A REFRACTION IS $30.00. IF THERE ARE ANY OTHER CHARGES YOUR INSURANCE WILL NOT COVER, WE WILL ASK YOU TO SIGN A WAIVER FOR THESE SERVICES. AT THE TIME OF SERVCICE WE WILL COLLECT THESE OUT-OF-POCKET FEES. PLEASE SIGN AND DATE BELOW THAT YOU HAVE READ AND UNDERSTAND THESE STATEMENTS.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Central Ohio Eye Physicians and Surgeons to furnish information to my insurance carriers and other physicians and healthcare providers concerning my illness and treatments. I hereby assign to Central Ohio Eye and its doctors all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance or authorized third party.

DATE: SIGNATURE

CENTRAL OHIO EYE PHYSICIANS & SURGEONS INC.
PATIENT FINANCIAL POLICY

We are committed to providing you with the best possible medical care; if you have special needs, we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

1. Our office participates with a variety of insurance plans. It is your responsibility to:
   a. Bring your insurance card to every visit, and make us aware of any changes in your coverage.
   b. Be prepared to pay our co-pay at each visit. Payment can be made by cash, check or credit card (Visa, MasterCard, or Discover). We are required by your insurer to collect this payment.
   c. For medical care not covered under your insurance, payment in full is due at the time of the visit.
2. If you have any insurance that we do not participate in, our office is happy to file the claim upon request, however, payment in full is expected at the time of service.
3. Referrals: It is your responsibility to bring any required referral for treatment at or prior to, the visit. If you do not have the referral, your visit may be rescheduled in non-emergency visits, or you may be financially responsible.
4. If the patient is a minor (under age 18), the parent or guardian must sign below. The parent, guardian, or unaccompanied minor is responsible for any payment due at the time of service, bringing the necessary referrals and insurance card. If parent is responsible for any bills, we will ultimately rely upon the parent who brought the child to the office as being financially responsible.
5. If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company's member services department (the number is on your insurance card).
6. If you fail to make payment in full for the services that are rendered to you, your outstanding balance may be forwarded for collection. You will be responsible for the fees assessed by the collection agency.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to our billing department at (614) 224-4297. Please sign that you have read and agree to this Financial Policy.

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Signature of Patient or Responsible Party Date

_____

Signature of Co-Responsible Party Date

PATIENT ACKNOWLEDGE OF RECEIPT OF PRIVACY NOTICE

I, _____**[Print Name of Patient]**, acknowledge that I received a copy of the Central Ohio Eye Physicians and Surgeons Inc., HIPAA Notice of Privacy Practices.

_____
Patient's Signature

_____
Date

Staff: If the patient did not acknowledge receipt of Privacy Notice above, you must document below your efforts to obtain the patient's acknowledgement and the reason why it was not obtained:

_____

_____

_____

CENTRAL OHIO EYE PHYSICIANS AND SURGEONS

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), limits the uses and disclosures of Protected Health Information ("PHI"). For these purposes, PHI means any information, including genetic information, (oral or recorded in any form or medium) that is created or received by health care provider (among others), identifies an individual and relates to: the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. PHI excludes information in education and employment records or regarding persons who have been deceased for more than 50 years.

OUR OBLIGATIONS

As a health care provider, Central Ohio Eye Physicians and Surgeons (sometimes referred to as "we") is required by law to maintain the privacy of PHI and, upon request, provide you with notice of our legal duties and privacy practices with respect to PHI and to notify you if a breach of your unsecured PHI occurs.

We are required to abide by the terms of this Notice until it is no longer in effect. We reserve the right to revise the terms of this Notice. If we revise this Notice, the revised Notice may apply to all the PHI that we have on the effective date of the revision, as well as to PHI created or received after that date. The revised Notice will be available upon request.

USES AND DISCLOSURES

This document will serve as your notice that we may use or disclose your PHI, without your authorization, in any one or more of the following ways:

We are required to disclose your PHI to you upon your request subject to some limitations described later.

We are also required to disclose your PHI to the Secretary of the Department of Health and Human Services in conjunction with that Department's regulatory authority over HIPAA compliance.

We may use and disclose your PHI to carry out treatment, payment or health care operations.

> Treatment--We may use or disclose your PHI to perform our professional services for you.
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> Payment--We may use or disclose your PHI to obtain payment for the healthcare services we provided. This may include disclosure to any employee benefit plan that covers our services on your behalf. We may use or disclose your PHI in judicial or administrative proceedings regarding payments for health care services we provided.
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> Healthcare Operations--We may use or disclose your PHI in order to support our business activities as a health care provider. These activities may include, but are not limited to, training physicians and employees and quality assessment.

We participate in an organized health care arrangement through OhioHealth Group, Ltd. (Health^4). Health^4 consists of an organized system of health care in which multiple covered entities participate. Through Health^4, we participate in joint activities that include utilization review, quality assessment and improvement activities, and certain payment activities. We may disclose your PHI to other participants in this organized health care arrangement in order to facilitate the healthcare operations activities of Health^4.

We may disclose your PHI to our agents (referred to as "business associates" in HIPAA regulations) in the course of our operations as a health care provider; for example, we may disclose your PHI to a person who transcribes our notes into medical records.

We may disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and/or to family or other individuals involved in your health care.

We may use or disclose your PHI to the extent required by federal or state law. The use or disclosure will be made in compliance with such federal or state law.

We may use or disclose your PHI for research purposes, provided an appropriate authority such as the Institutional Review Board has waived requirement for individual authorization for disclosure.

We may disclose your PHI to health oversight governmental agencies for such agencies authorized activities.

We may disclose your PHI for law enforcement purposes such as responses to legal processes or requests for information about identification or location, or injuries to victims of crimes.

We may disclose your PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

We may disclose your PHI if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person of the public.

We may disclose your PHI for national security purposes.

We may disclose your PHI for public health activities relating to controlling disease, communicable diseases, injuries, disabilities, or bioterrorism.

We may disclose your PHI in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal or in response to a subpoena, discovery request, or other lawful process.

We may disclose your PHI to a coroner or medical examiner for such officials to perform their authorized duties. We may disclose your PHI to a funeral director in order for a funeral director to perform authorized duties.

We may disclose your PHI to comply with worker's compensation laws and other similar programs.

Disclosures, incidental to the permitted disclosures describes above, may occur.

Other uses and disclosures of your PHI will be made only with your written authorization. Those uses and disclosures are limited to (1) psychotherapy notes, (2) marketing purposes, and (3) the sale of your PHI. You may revoke such an authorization, at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR INDIVIDUAL RIGHTS

Inspection and copying — You have the right to inspect the PHI about you or about your minor child that is contained in our designated record set. Our designated record set contains medical, billing and payment records that we generate, have generated, and use to perform health care for you. You have the right to obtain a copy, (in electronic or paper form),for a reasonable fee, of all or part of the designated record set of your PHI, subject to some limitations. For example, you may not inspect or copy psychotherapy notes, or information complies in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding.

Restriction of PHI — You have the right to request a restriction of use or disclosure of your PHI, or your minor child's PHI, for treatment, payment, or health care operations or disclosure to family members or others who may be involved in your care as described above in this Notice of Privacy Practices. You should understand that this restriction may hamper treatment or payment for your health care services. You should make this requests in writing to the Privacy Officer listed below, specifically designating the PHI that you want us to refrain from disclosing. We are not required to agree to the restrictions that you may request, unless your request involves (1) disclosures for the purpose of carrying out payment or health care operations, or (2) services or items for which you have paid us in full .

Request of confidential communications — You have the right to request to receive confidential communications from us by alternative means or at an alternative location if customary disclosure would endanger you. We will accommodate reasonable requests, within our ability to comply, at a reasonable fee.

Amendment of PHI — You have the right to request that we amend your PHI, in a designated record set, for as long as we maintain this information. To do so, your request must be made in writing, to the Privacy Officer listed below. Your request may be denied if the information: was not created by us; is not part of our designated record set; would not be available for inspection; or is accurate and complete.

Accounting of disclosures — You have the right to request and receive an accounting of certain disclosures we have made of your PHI. The accounting excludes disclosures made: before September 23, 2013, for treatment, payment or health care operations; as you authorized; to family members or friends involved in your care; for national security purposes; incidental disclosures and to law enforcement officials.

Paper copy – You have the right to request a paper copy of this Notice, even if you agree to receive the Notice electronically

Complaints — You have the right to complain to the Secretary of Health and Human Services if you believe we have violated your privacy rights. You may file a complaint with us by notifying our Privacy Contact of your complaint. We are not permitted to retaliate against you for filing a complaint.

PRIVACY CONTACT

Privacy Officer
Nadine Eggleston
262 Neil Ave Suite 420
Columbus, OH 43215
614-224-4297

HIPAA PROCEDURES AND OTHER LIMITATIONS

HIPAA regulations also provide for certain procedures for implementing your rights as summarized above and for reviewing denied requests. This Notice is a summary, not a definitive description of HIPAA rights and requirements, and HIPAA may impose additional limitations on your rights.

EFFECTIVE DATE

This Notice is effective beginning the 3rd of January 2017.